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b. Psychiatric Hospitals

Designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals are this type of facility. This currently includes, but is not limited to, Fairfax Hospital, Pine Crest Hospital, Pacific Gateway Hospital, the children's psychiatric unit at Sacred Heart Hospital, and the psychiatric unit at Children's Hospital & Medical Center.

c. Rehabilitation Units

Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The criteria used to identify exempt hospitals and units are the same as those employed by the Medicare program to identify designated distinct part rehabilitation units. In addition, recipients in the MAA Physical Medicine and Rehabilitation program (PM&R), who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for placement into the rehabilitation unit or the rehab service will be paid DRG.

d. Managed Health Care

Payments for recipients who receive inpatient care through managed health care programs. If a client is not a member of the plan, reimbursement for admissions to managed health care program hospital will be determined in accordance with the applicable payment methods for contract or non-contract hospitals described in Section D, Section E and/or Section F.

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e. Out-of-State Hospitals

Out-of-state hospitals are those facilities located outside of Washington and outside designated border areas as described in Section D. These hospitals are exempt from DRG payment methods, and are paid an RCC ratio based on the weighted average of RCC ratios for in-state hospitals.

f. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed charges.

8. DRG Exempt Services

a. Neonatal Services

DRGs 620 and 629 (normal newborns) are reimbursed by the DRG payment method. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 neonatal services are exempt from the DRG payment methods, and are reimbursed under the RCC payment method.

b. AIDS Related Services

AIDS related inpatient services are exempt from DRG payments methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) and other Human Immunodeficiency Virus (HIV) infections.

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

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d. Level II Inpatient Acute Physical Medicine and Rehabilitation Services

Level II Inpatient Acute Physical Medicine and Rehabilitation (PM&R) services are exempt from DRG payment methods. Level II PM&R services are provided under contract and reimbursed using a fixed per diem rate. Hospitals and skilled nursing facilities must request and receive a Level II PM&R designation. Care is authorized and provided on a case-by-case basis.

e. Bone Marrow And Other Major Organ Transplants

Services provided to recipients receiving bone marrow transplant and other major organ transplants are exempt from the DRG payment method, and are reimbursed under the RCC method.

f. Chemically-Dependent Pregnant Women

Hospital-based intensive inpatient care for detoxification and medical stabilization provided to chemically-dependent pregnant women by a certified hospital are exempt from the DRG payment method, and are reimbursed under the RCC payment method.

9. Transfer Policy

For a hospital transferring a recipient to another acute care hospital, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below, the payment to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital; or, the appropriate DRG payment.

If a recipient is transferred back to the original hospital and subsequently discharged, the original hospital is paid the full DRG payment. It is not paid an additional per diem as a transferring hospital. The intervening hospital is paid a per diem payment based on the method described above.

The hospital that ultimately discharges the recipient is reimbursed the full DRG payment; however, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied.

10. Readmission Policy

Readmissions occurring within 7 days of discharge will be reviewed to determine if the second admission was necessary or avoidable. If the second admission is determined to be unnecessary, reimbursement will be denied. If the admission was avoidable, the two admissions may be combined and a single DRG payment made. If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon a utilization review of the case.

11. Administrative Days Policy

Administrative days (42 CFR 447.253(b)(1)(B)) are those days of hospital stay wherein an acute inpatient level of care is no longer necessary, and an appropriate non-inpatient hospital placement is not available. Administrative days are reimbursed at the statewide average Medicaid nursing home per diem rate.

For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The administrative rate is adjusted November 1.

For DRG exempt cases, administrative days are identified during the length of stay review process.

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12. Short Stay Policy

Stays of less than or approximating 24 hours where an admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, a delivery, or initial care of a newborn are reimbursed under the DRG payment methods.

13. Medicare Crossover Policy

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For recipients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider can not exceed the department's rates or fee schedule as if they were paid solely by Medicaid.

In cases where the crossover recipient's Part A benefits including lifetime reserve days are exhausted and the Medicaid outlier threshold status is reached, the state will pay for those allowed charges beyond the threshold using the outlier policy described above.

14. Third-Party Liability Policy

For DRG cases involving third-party liability (TPL), a hospital will be reimbursed the applicable DRG amount for the case minus the TPL amount. For RCC cases involving TPL, a hospital will be reimbursed the RCC amount minus the TPL amount.

15. Day Outliers:

Section 1923(a)(2)(C) of the Act, requires the state to provide payment adjustment for hospitals for medically necessary inpatient hospital services involving exceptionally long length of stay for individuals under the age of six in disproportionate share hospitals and any hospital for a child under age one. A hospital is eligible for the day outlier payment if it meets the following:

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a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.

b. The patient payment is DRG.

c. The charge for the patient stay is under $28,000 (cost outlier threshold).

d. Patient length of stay is over the day outlier threshold for the applicable DRG.

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate.

Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

D. DRG COST-BASED RATE METHOD

The DRG cost-based rate is a calculated hospital specific dollar amount that is multiplied by the applicable DRG weight to produce the DRG payment. The rate has three components (operating, capital and direct medical education). The rate is established on the basis of hospital's average cost for treating a Medicaid patient during a base period. This amount is adjusted for the hospital's case mix and updated for inflation.

1. Base Period Cost and Claims Data

The base period cost data for the rates are from hospitals' Medicare cost reports (Form HCFA 2552) for their fiscal year (FY) 1993. Cost data that was desk reviewed and/or field audited by the Medicare intermediary was used in rate setting when available.

Three categories of costs (total costs, capital costs, and direct medical education costs) were extracted from the HCFA 2552 for each of the 38 allowed categories of cost/revenue centers used to categorize Medicaid claims.

Nine categories were used to assign hospitals' accommodation costs and days of care, and 29 categories were used to assign ancillary costs and charges. Medicaid paid claims data for each hospital's FY 1993 period were extracted from the state's Medicaid Management Information System (MMIS). Department of Health Composite Hospital Abstract Reporting System (CHARS) claims matching managed care claims submitted by hospitals were also extracted. Line item charges from claims were assigned to the appropriate 9 accommodation and 29 ancillary cost center categories and used to apportion Medicaid costs. These data were also used to compute hospitals' FY 1993 case-mix index.

2. Peer Groups & Caps

The Washington State Department of Health's (DOH) peer group methodology was adopted for rate-setting purposes. The peer grouping has four classifications: Group A, which are rural hospitals paid under an RCC methodology; Group B, which are urban hospitals without medical education programs; Group C, which are urban hospitals with medical education programs; and Group D, which are specialty hospitals.

Indirect medical education costs were removed from operating and capital costs, and direct medical education costs were added. Peer group caps for peer groups B and C were established at the 70th percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs. In computing hospitals' rates, hospitals whose costs exceeded the 70th percentile of the peer group were re-set at the 70th percentile cap. The hospitals in peer group D were exempted from the caps because they are specialty hospitals without a common peer group on which to base comparisons.

Changes in peer group status as a result of DOH approval or recommendation will be recognized. However in cases where post-rate calculation corrections or changes in individual hospital's base-year cost or peer group assignment result in a change in the peer group cost at the 70th percentile, and thus would have an impact on the peer-group cap, the cap will be updated only if it would result in a 5.0 percent or greater change in total Medicaid payment levels.

3. Conversion Factor Adjustments

Indirect medical education costs were added back into costs before application of any inflation adjustment. A 0.007836 percent per day inflation adjustment (2.86 percent divided by 365 days) was used for hospitals that have their fiscal year ending before December 31, 1993. A 7.71 percent inflation adjustment was used for the period from January 1, 1994 to September 30, 1996.

On November 1 of each year commencing on November 1, 1999, all conversion factors will be increased by the latest available forecast by Data Resources, Inc., of market basket inflation for hospital operating expenses, (such forecast to be of the type used by HCFA in the development of its PPS update).

4. Medicaid Cost Proxies

In some instances, hospitals had Medicaid charges (claims) for certain accommodation or ancillary cost centers that were not separately reported on their Medicare cost report. To ensure recognition of Medicaid related costs, proxies were established to estimate these costs. Per diem proxies were developed for accommodation cost centers; RCC proxies for ancillary cost centers.

5. Case-Mix Index

Under DRG payment systems, hospital costs must be case-mix adjusted to arrive at a measure of relative average cost for treating all Medicaid cases. A case-mix index for each hospital was calculated based on the Medicaid cases for each hospital during its FY 1993 cost report period.

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6. Indirect Medical Education Costs

An indirect medical education cost was established for operating and capital components in order to remove indirect medical education related costs from the peer group caps. To establish this factor, a ratio based on the number of interns and residents in approved teaching programs to the number of hospital beds was multiplied by the Medicare's indirect cost factor of 0.579. The resulting ratio was multiplied by a hospital's operating and capital components to arrive at indirect medical education costs for each component. The indirect medical cost was trended forward using the same inflation factors as apply to the operating and capital components and added on as a separate element of the rate as described in paragraph 7.

7. Rate Calculation Methodology

Step 1: For each hospital the base period cost data were used to calculate total costs of the operating, capital, and direct medical education cost components in each of the nine accommodation categories. These costs were divided by total hospital days per category to arrive at a per day accommodation cost. The accommodation costs per day were multiplied by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

Step 2: The base period cost data were also used to calculate total operating, capital and direct medical education costs in each of the 29 ancillary categories. These costs were divided by total charges per category to arrive at a cost-to-charge ratio per ancillary category. These ratios were multiplied by MMIS Medicaid charges per category to arrive at total Medicaid ancillary costs per category for the three components.

Step 3: The Medicaid accommodation and ancillary costs were combined to derive the operating, capital and direct medical education's components. These components were then divided by the number of Medicaid cases to arrive at an average cost per admission.

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Step 4: The three components' average cost per admission were next adjusted to a common fiscal year end (December 31, 1993) using the appropriate DRI-HCFA Type Hospital Market Basket update and then standardized by dividing the average cost by the hospital's case-mix index.

Step 5: The indirect medical education portion of operating and capital was removed for hospitals with medical education programs. Outlier costs were also removed. For hospitals in Peer Group B and C, the three components aggregate cost was set at the lesser of: hospital specific aggregate cost or the peer group cap aggregate cost.

Step 6: The resulting respective costs with the indirect medical education costs and an outlier factor added back in were next multiplied by the DRI-HCFA Type Hospital Market Basket update for the period January 1, 1994 through September 30, 1996. The outlier set aside factor was then subtracted to arrive at the hospital's July 1, 1996 cost-based rate. This cost-based rate is multiplied by the applicable DRG weight to determine the DRG payment for each admission.

Those in-state and border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

8. Border Area Hospitals Rate Methodology

Border area hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Couer D'Alene - Lewiston, Moscow, Priest River and Sandpoint.

These hospitals' cost-based rates are based on their FY 1993 Cost Reports and FY 1993 claims, if available. Those border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.